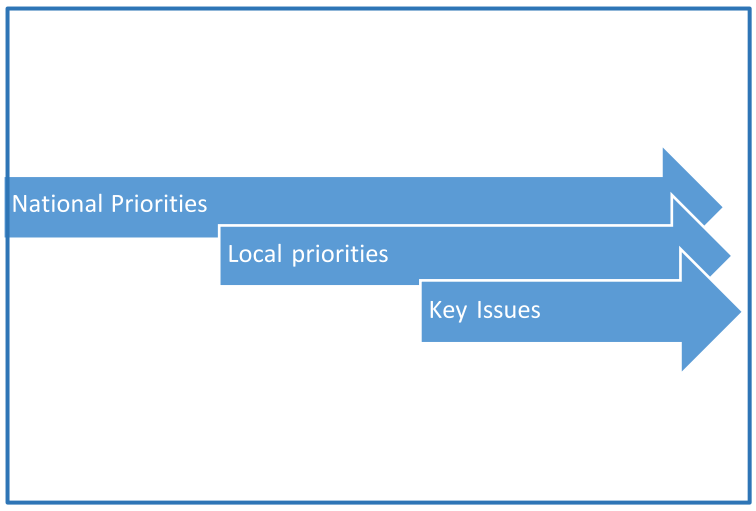
Section 1 – Narrative

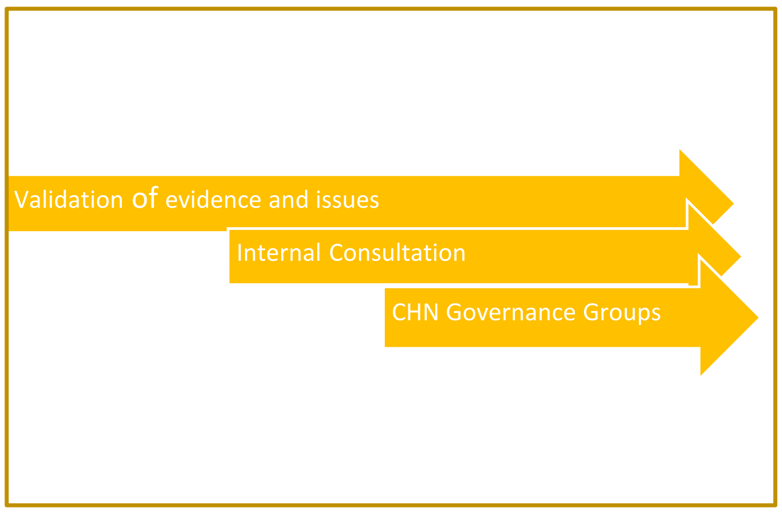
Needs Assessment process and issues (500-1000 words)

ACT Primary Health Network (ACT PHN) utilised a new process to ensure strong governance and processes are in place to carry out the Needs Assessment.

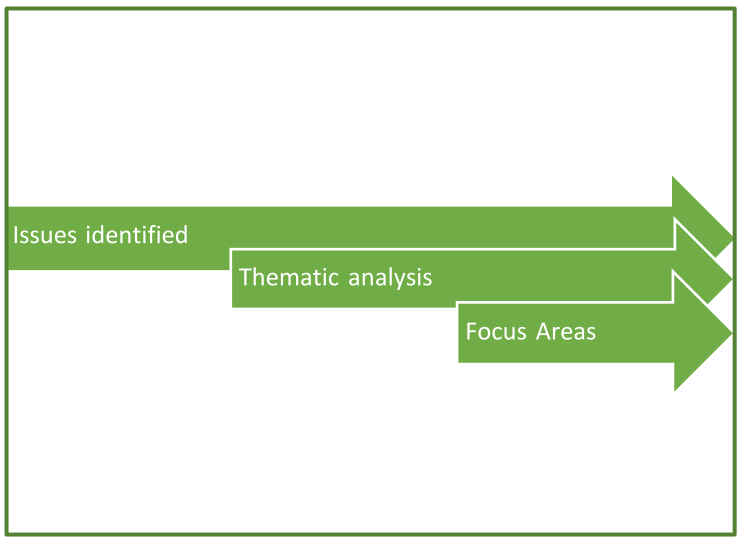
Stage 1: Identifying priorities



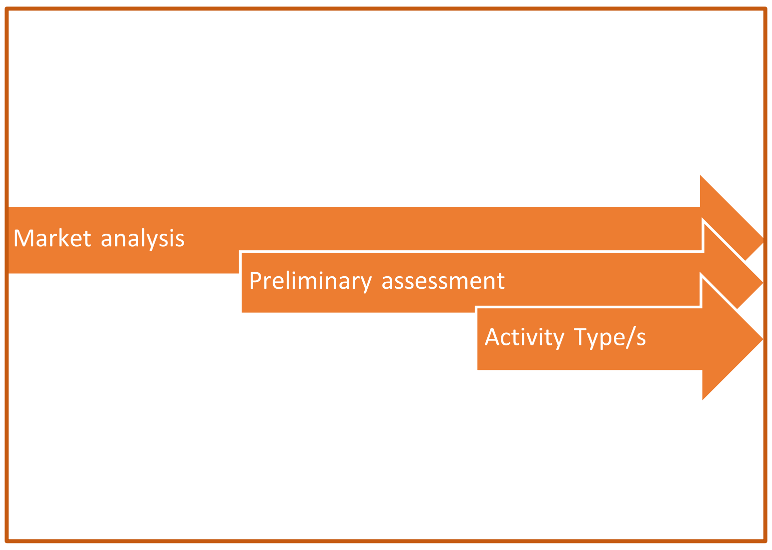
Stage 2: Validating evidence



Stage 3: Identifying themes and options



Stage 4: Defining activities



The process for this Needs Assessment has involved an update of the quantitative information contained in the previous Needs Assessment and further collection of qualitative data via consultation. As in previous years' Needs Assessments, we also included a focus on local vulnerable populations and focus areas identified by key stakeholders including the Community Advisory Council, ACT Clinical Council and General Practice Advisory Committee. These foci include disabilities and the NDIS, children and young people, carers, families with complex health and social care needs, digital health, people exiting prison, people living with blood borne viruses and chronic pain management.

We continue to utilise existing networks (providers and consumers) and key informants to provide information or seek validation around the articulation of issues. This has included the Community Advisory Council, ACT Clinical Council, General Practice Advisory Committee, staff and other local stakeholders and subject matter experts.

As with the previous Needs Assessments, the consultation data was analysed thematically alongside local data wherever available. The consultation data has added invaluable anecdotal evidence to the overall picture provided by the quantitative data and information. Any relevant findings from community consultations undertaken by other organisations was incorporated into the needs assessment findings.

Community consultation is an ongoing process and will continue to occur beyond the needs assessment process, as it is essential to ensure that population health needs are accurately reflected and that plans and actions are appropriate. An ACT PHN community and consumer engagement framework has been developed and this framework provides guidance on the various engagement strategies that may be most effective at various stages of the commissioning cycle.

We continue to consider it important to collect information about health inequalities in the ACT population and to have a focus on those groups who are disadvantaged or vulnerable. There are vulnerable populations in the ACT that are at greater risk of poor physical, psychological and/or social health status and health care access. For these vulnerable populations, there is a need to understand the link between social determinants of health and how these affect health outcomes. Stakeholder engagement in relation to issues for vulnerable populations will be ongoing as part of the commissioning process.

We will also continue to work closely with the ACT Government (Health, Community Services, Justice and Education Directorates) to ensure that we have maximum alignment of priorities where possible and to support an integrated approach to improving health outcomes in our jurisdiction.

Additional Data Needs and Gaps (approximately 400 words)

The ability to obtain comprehensive data on target populations at the sub-regional level in the ACT continues to be a challenge as is the ability to access relatively recent data. We welcome the improvement in the release of Commonwealth data to assist PHNs. In particular, data that brings together health data with social and community services data to provide a more detailed view about the impact of the social determinants of health would be of significant use.

Where possible, ACT PHN attends the PHN Data Collaboration Network meetings organised by AHHA which is a good forum for networking in relation to the use of health data and to hear about what others are doing regarding sourcing, analysing and presenting their data. The Population Health team are members of the NSW/ACT PHN Population Health, Data and Information Network (PHDIN).

Additional comments or feedback (approximately 500 words)

ACT PHN's Needs Assessment process will be refined and evaluated. ACT PHN is undertaking a process to ensure that all activities, outcomes, and reporting (Activity Work Plans, Key Reporting Activities and the National Quality Performance Framework) are informed and can map to needs identified in the Needs Assessment. As we move to a three year full Needs Assessment cycle, we are also establishing new strategies and processes for ensuring ongoing, robust planning continues and informs our work into the future. All processes will include examination of national, territory-level, and more localised sources of data, community consultation and stakeholder engagement, and community mapping.

Section 2 – Summary of needs assessment and outcomes

Key Priority Area	Issues	Description of Evidence and Supporting Information	Target outcome	Possible options/Focus area	Primary PHN Activities - up to 3 (Awareness raising, Procurement activity, Strategic relationship, Workforce development)	Lead
1. Care across the Continuum	1.1 Sharing of clinical information across care settings	33% of GP survey respondents to The Canberra Hospital's 2015 General Practice Survey said that it was rarely or never clear who was responsible for following up results and 47% said that this usually resulted in clinical consequences to the patients. Poor communication between different parts of the health system often results in delays in appropriate treatment or community supports, duplication of diagnostic tests and in some cases re-hospitalisation. The quality of communication between different parts of the health system has considerable implications for patients, the health care system and health care costs. The transfer of information between care providers is an essential component of any transfer to ensure patient safety. Apart from the risk of achieving sub-optimal outcomes, poor communication wastes both patients' and clinicians' time and ultimately health system resources. Outpatient clinic communication issues were particularly prominent with GP comments including: • delays in receiving responses, • difficulties in accessing clinicians required • A general sense that the system was overburdened and unable to respond effectively.	Information is shared across health settings. Healthcare providers to use digital health systems to improve patient care and communication.	Understanding current perceptions of opportunities and barriers for improved communication and information sharing: • Updated GP survey to obtain new data. Improving information sharing through: • Continued promotion of My Health Record and optimising use of the platform across care settings • Continued collaboration with ACT Health around e-health strategy.	Workforce development Strategic relationship	ACT PHN
	1.2 Handover of post-hospital care	33% of Canberra Hospital and 43% of Calvary Hospital discharge summaries are rated average or below average (GPLU, 2015a). Accurate information is a fundamental building block for coordination of comprehensive consumer focused care and the development and up-to-date maintenance of referral pathways. Audits show significant quality issues with discharge summaries around timeliness, recording of principal diagnoses, complications and medications. This issue has been raised by GPs, specialists, allied health providers, alcohol and drug service stakeholders, mental health providers, Aboriginal and Torres Strait Islander community representatives and refugee advocates as well as: • There is a lack or perceived lack of clearly articulated follow-up arrangements post discharge. • This level of performance with regards to discharge information poses safety and quality risks for patients and makes continuity of care a major challenge.	Primary care teams have timely access to discharge information. Patients experience a coordinated transition between hospital and primary care.	Improving collaboration and planning activities with acute services by: • Continued engagement with ACT Health on review of discharge planning systems. • Advocating for discharge planning to include patient-centred principles that include the patients, family and carers in planning and implementation.	Strategic relationship	ACT Health

		There is significant evidence that active integration of community and social support networks addressing needs of patients discharged from hospital is one of the top three interventions associated with success in reducing re-admissions.				
	1.3 Need for better shared care arrangements between primary and outpatient services	Current growth in demand for outpatient services is unsustainable and is already well beyond capacity. ENT, urology, neurology, endocrinology and dermatology are currently significant outpatient pressure points in the ACT that require better defined shared care arrangements. The following have been highlighted by stakeholders as significant issues: • Variability in how referrals are organised • Lack of an effective e-referral system • Multiple referral pathways • Lack of shared decision making • Referral back to GP: clinical feedback is not timely • There is a lack of private speciality options with current availability.	Improved quality and appropriateness of referrals to outpatient services. Healthcare providers to use digital health systems to improve patient care and communication. Primary care workforce feels supported to safely manage patients in the community.	Developing opportunities for shared care by: • Continued engagement with ACT Health and GP Liaison Unit in the development of a Waiting List Reduction Strategy • Research, develop, and pilot models for shared care arrangements in specialities experiencing significant outpatient pressure • Continue promoting HealthPathways to ensure quality referrals.	Strategic relationship Workforce development	ACT Health
	1.4 Difficulties in accessing primary care or care in the community/home setting in the after-hours period.	Significant resources are provided by governments for after hours care but could be more effectively targeted and integrated, particularly for urgent care. There is emerging evidence that integration of general practice models with emergency departments (EDs) produces good outcomes at: • Systems level including better utilisation of clinicians, less diagnostics and improved coordination with primary and community care • Individual level including shorter waiting times, more appropriate match of clinician to type of need and improved coordination with primary and community care. In the ACT the Canberra After Hours Locum Medical Service (CALMS) infrastructure is already in place which may be able to sustain a more integrated model, but to date insufficient integration between EDs and CALMs has occurred. The ACT has three Walk-in Centres (with two more being planned). These centres are opened for extended hours and offer free services for minor injury and illness, however, are limited in the services they provide and also have to refer to ED and GPs. There is sufficient evidence about the efficacy of integrating ambulance services into primary health care networks to support after hours service provision. Patients with minor illnesses and injuries, who are able to be treated by a paramedic at their own homes (or in Residential Aged Care Facilities (RACFs)), are less likely to be transported to ED or need hospital admission within 28 days and there are potential savings to be recognised given the high cost of ambulance services and subsequent treatment in ED.	Access to after hours care in a primary care setting. General practices and other health care providers are supported to provide after hours care.	Integrating the after-hours service landscape in the ACT: • Work with stakeholders to identify and implement initiatives to improve integration in the after hours service landscape • Continue to work in partnership with ACT Health to implement a comprehensive whole of community awareness campaign on after hours options, with a focus on families with young children (0-4) and 18 to 25 year olds. • Continue commissioning after-hours services.	Procurement Strategic relationships	ACT PHN
	1.5 Limited access to after-hours primary care in RACFs contributing to	RACFs have reported difficulty in accessing primary care during the after hours period, particularly for rapid responses for deteriorating patients. No acute care rapid GP response service exists in the ACT. MBS data indicates a low per capita number of RACF GP visits in the after hours period compared to the Australian average.	Access to primary health care including in the after hours period, for people	Support collaboration between acute services, general practice, and Residential Aged Care Facilities:	Procurement Workforce development	ACT PHN

	presentations to and time spent in hospitals	Evidence shows that the elderly have higher rates of ED re-presentation, admission to hospital and inferior clinical outcomes after discharge from ED. Strategies which allow the population to be treated where they are, rather than being transported to hospital, are important when considering this elderly cohort. There are international and local examples of extended paramedics, or 'see and treat' models, or Geriatric Rapid Acute Care Evaluation (GRACE) models, which have been effective in improving patient outcomes and reducing hospital admissions. The GRACE model of care trialled within five RACFs in the ACT offers clinical support to RACFs by providing a point of liaison at the FACF/acute care interface with the aim of improving patient outcomes for the acutely unwell residents.	living in residential aged care settings. Fewer preventable hospitalisations in the PHN region for older people.	• Commission services that provide clinical support to RACFs and a point of liaison between GPs, RACFs, and acute services for acutely unwell residents. • Co-design capacity building initiatives with GPs and RACFs • Disseminate learnings and develop business case for service models in the ACT.		
	1.6 Consumer awareness and perceptions about the need for diagnostic services in the after hours period.	There is limited access to diagnostic services such as radiology and pathology during the after hours period (particularly co-located with general practice). The awareness of this within the community results in people choosing to attend ED as a "one stop shop" rather than having to visit numerous providers.	Consumers are supported to understand after hours service options and feel supported to access the right level of care at the right time.	Raise community awareness about the safety and quality of care in primary care after hours services.	Community awareness	ACT PHN
	1.7 Limited awareness of After Hours services in the ACT.	Data from a 72 hour ED snapshot survey undertaken by ACT Medicare Local in 2013 shows that when respondents were asked about their knowledge of after hours services available, there were significant gaps (i.e. fewer than 50% of participants were aware of extended hours general practice). The ACT Health Care Consumers Association have identified 'navigating the system and identification of the right service for the consumer's needs' as a significant barrier to access in the ACT. International literature suggest that a patient's perception of urgency is a key part of the decision making process when choosing where/how to access care. Drivers of health care seeking behaviour vary between population groups. Initiatives need to be targeted at providing the right care, at the right time to the right patient, even if they are in the 'wrong place'. The perception of urgency can often negate awareness raising campaigns due to heightened anxiety and stress levels during periods of illness. While the evidence about the utility of community awareness campaigns is marginal at best, there is very little evidence about segmented targeting of various population cohorts within the market, nor the impact of new forms of social media on this. Targeting parents of 0-4 year olds and the 18-24 year old cohort via social media may be worthwhile.	Access to primary care after hours services. Consumers are supported to understand after hours service options and feel supported to access the right level of care at the right time.	Develop and evaluate community awareness activities targeting specific population groups based in local utilisation data.	Community awareness	ACT PHN
2. Aboriginal and Torres Strait Islander Health	2.1 High rates of mental ill health among Aboriginal & Torres Strait Islander people	In ACT, almost one third of Aboriginal and Torres Strait Islander people reported having a high level of psychological distress which is 3.4 times higher than the non-Indigenous population. The ACT rate of hospitalisation for principal diagnosis of mental health related conditions is 1.9 times higher than the non-Indigenous population. For Aboriginal and Torres Strait Islander females, the age-standardised hospitalisation rate for self-harm was 2.6 times the rate for non-Indigenous females, 4.0 per 1,000 compared with 1.5 per 1,000 in July 2013 to June 2015.	Improved Social Emotional Wellbeing for Aboriginal and Torres Strait Islander People. Aboriginal and Torres Strait Islander people have access to culturally appropriate care in the community.	Improve access to culturally responsive mental health care: • provision of support to primary health care professionals around working with Aboriginal and Torres Strait Islander People with mental health related illness, including cultural awareness	Procurement Workforce development	ACT PHN

		Aboriginal and Torres Strait Islander people in the ACT accessed the community mental health services at a rate of 2.6 times higher than the non-Indigenous population. Stakeholder feedback highlighted difficulties around access to services when a client does not meet the eligibility requirements and advised that there is a lack of services available to those experiencing mild to moderate mental ill health.		training and access to resources and referral pathway information • Continue to commission and evaluate culturally appropriate psychological interventions for Aboriginal and Torres Strait Islander People. • Develop Cultural Safety Framework for commissioned providers.		
	2.2 Barriers to accessing mainstream primary care services resulting in higher risk of poorer health outcomes	Aboriginal and Torres Strait Islander patients and families experience barriers when trying to access mainstream primary health care services, including: - Long wait times - Lack of bulk-billing in many practices - Lack of information about which practices are "incentivised" to provide primary care to this population group - Service not available at the time required - Transport or distance - Services not available in their suburb - Discrimination or language problems - Dislike of service or professional - Embarrassed or afraid - Felt the service would be inadequate - Did not trust the service Some GPs may not provide the types of services required by many Aboriginal clients with complex needs, resulting in clients needing to travel some distance for appropriate services. In the ACT, the age-standardised rate of disability or restrictive long-term health condition was almost twice as high for Indigenous Australians as for non-Indigenous Australians, 48% compared with 26% in 2014–15.	Improved primary health service provision for Aboriginal and Torres Strait Islander People. Aboriginal and Torres Strait Islander people have access to culturally appropriate care in the community.	Support mainstream services to deliver culturally responsive care and collaborate with Aboriginal and Torres Strait Islander specific services: • Provision of support to primary health care professionals around working with Aboriginal and Torres Strait Islander people, including cultural awareness training and access to resources and referral pathway information. • Continue to commission culturally appropriate services models for Aboriginal and Torres Strait islander people aimed at improving coordination and addressing barriers to access. • Scope opportunities to integrate with GP quality improvement initiatives. • Develop a Cultural Safety Framework for commissioned providers.	Procurement Workforce development	ACT PHN
	2.3 Access to culturally appropriate AOD services and resources for the Aboriginal and Torres Strait Islander community in the ACT	There is a disproportionate burden of alcohol and other drug related harms experienced by Aboriginal and Torres Strait Islander people in the ACT region. In the ACT, the age-standardised rate of hospitalisation for a principal diagnosis related to alcohol use for Aboriginal and Torres Strait Islander people was 3.5 times the rate for non-Indigenous Australians. 25% of the current ACT AOD treatment population identify as Aboriginal and Torres Strait Islander (Service User Satisfaction and Outcomes Survey, 2015).	Improved AOD service provision for Aboriginal and Torres Strait Islander People. Aboriginal and Torres Strait Islander people have access to culturally appropriate care in the community.	Continue to commission culturally appropriate services for individuals and families. Facilitate collaboration between Aboriginal and Torres Strait Islander specific commissioned services. Develop new resources.	Procurement	ACT PHN

		A national survey of Aboriginal and Torres Strait Islander community controlled services and AOD services reported that 79% of respondents identified methamphetamines as a significant issue for Aboriginal and Torres Strait Islander clients. The ACT Aboriginal Community Controlled Health Organisation (ACCHO) reported that over the last two years there has been a significant increase in the use of methamphetamine, with an increase in presentations at the ACCHO. Over a four month period in 2015 four young male members of the Aboriginal Community died as a result of methamphetamine use. An Aboriginal and Torres Strait Islander youth based service in the ACT reported an increase in methamphetamine use in the youth community, which also has a broader impact on family members. The youth service has identified that their workers are not appropriately trained to support clients using methamphetamine and their families. They also identified that there were a lack of culturally appropriate methamphetamine and broader AOD related resources to provide to clients. Evidence suggests substance use increases the risk of incarceration, which is another significant issues for the Aboriginal and Torres Strait Islander community in the ACT, with a disproportionate percentage of inmates identifying as an Aboriginal and Torres Strait Islander.	Primary health care professionals feel supported to identify, manage, and refer patients with AOD concerns.	Develop a Cultural Safety Framework for commissioned providers.		
3. Digital Health	3.1 Perceived lack of awareness and skills in the use of technology to enable safe and streamlined communication of clinical information	My Health Record adoption and integration into everyday clinical use within general practice in the ACT is improving slowly. The My Health Record registration within general practice is at 86% of practices. Levels and consistency of use across GPs is inconsistent and not all registered practices are using the platform. Of the 14% of practices that have not registered for My Health Record, 2 of these practices have not adopted electronic clinical information systems. My Health Record adoption across the ACT in other health services is limited but increasing: • Community pharmacy – 45% registration and 38% use • Residential Aged Care Facilities – 19% registered however none are using My Health Record • GP after hours services – none are registered for or using My Health Record My Health Record adoption by allied health practitioners and medical specialists is dependent on the integration of the clinical software with the My Health Record system. The adoption of secure messaging services to securely send and receive clinical information has been adopted by the majority of general practices. GPs primarily use secure messaging to receive information but do not utilise the sending capability. The lack of adoption of secure messaging by other private health services including pharmacy and residential aged care is due to a lack of awareness and lack of integrated capability with the existing clinical information systems.	Health care providers are aware of digital health systems and technologies Health care providers are supported to use digital health systems to improve patient care and communication.	Optimise use of digital technology to improve communication and coordination of care: • Support primary health care providers in fully utilising My Health Record • Support allied health providers to utilise My Health Record and address integration issues. • Raise awareness, understanding and adoption of secure messaging and e-referrals among GPs and other health service providers • Scope opportunities to integrate digital health into GP quality improvement initiatives.	Workforce development	ACT PHN
	3.2 Lack of awareness and skills to use technology as a tool to support one's own health	The Digital Health team has identified a number of barriers to accessing My Health Record for people who do not know how or do not have ready access to the internet. These people include older persons, people with disabilities, homeless and some people in the CALD communities.	Consumers and their carers/families are empowered and supported to utilise digital health technologies.	Collaborate with consumer groups and other digital health initiatives build the skills of consumers to utilise My Health Record and other health technologies.	Strategic Relationships	ACT PHN in partnership with local consumer groups.

			Positive health outcomes are supported through the use of digital technologies.			
4. Mental Health	4.1 Barriers to accessing early intervention services	Early intervention promotes more effective recovery, and can reduce the duration of an illness and decrease the negative impact of mental illness on people, families and the community over the course of their life. Prevention and early intervention can also reduce the need for hospitalisation and inpatient facilities. Stakeholder feedback has highlighted the importance of a focus on appropriate, evidence based early intervention and prevention based services for those suffering from ill mental health. Stakeholders highlighted the need for an increase in mental health promotion activities for the community, as well the role GPs can play in promoting online mental health resources to all patients who present with mental health concerns. Stakeholders stated that mental health consumers often struggle to access appropriate services early in illness and episode due to eligibility criteria, for example Psychological Therapies and ACT Health services. The system as a whole is not responsive to changing demand or client needs and therefore can be inaccessible for many. Stakeholders identified the lack of resources and capability to support families, carers and peers to access early intervention services, including description of services and referral pathways. Stakeholders highlighted the importance of addressing anxiety and depression symptoms before high school for the 8-12 year old cohort. It was identified by stakeholders that this cohort experience access barriers to early intervention services including lack of teacher/school awareness of mental health conditions and referral pathways, lack of school counsellor capacity, high demand and lack of capacity for child and family based services, including Cool Kids and Worry Busters. Through the ACT Primary Health Network Mental Health Centralised Intake and consultation with stakeholders, the need for affordable assessment services for children under 12 has emerged. GPs and School Counsellors are often seeing children under the age of 12 that require a psychological assessment from a suitably trained and experienced mental health professional, but have limited referral pathways for parents who cannot afford to pay for assessments to be completed privately. Parents cannot access these types of services for their children through Better Access, which only focuses on the provision of focused psychological strategies.	Access to early intervention in life, illness and episode. Improved client outcomes including achieving recovery in the current episode of care.	Facilitate sector-wide collaboration to develop a responsive, accessible services: • Continue to identify opportunities for joint or co-commissioned activities with ACT Health • Continue collaboration with Canberra Health Services around integrating intake services and developing clear referrals pathways and shared care between services (i.e. primary, secondary and tertiary care). • Develop demand management strategies to address waitlists and ensure services are received when needed. • Ensure availability of services across the lifespan and stepped care continuum by commissioning services where there are gaps. • Engage consumers in designing client-centred services • Continue to commission services that facilitate access to earlier intervention i.e. low intensity services.	Procurement Strategic relationships	ACT PHN
	4.2 Poor physical health in those with severe mental illness	There is strong evidence to indicate that people who experience severe mental ill health have poor physical health outcomes. This is the result of a lack of physical care at the right time and side effects of psychotropic medication, often leading to chronic diseases such as Type 2 Diabetes and Cardiovascular Disease. Stakeholder feedback has highlighted the importance of improved awareness of Metabolic Disorder, education for GPs and the importance of people who experience mental ill health having a regular GP in the community.	Positive physical health outcomes for people with ill mental health.	Utilise the Equally Well Framework to inform and guide development of activities that provide integrated care for people with mental illness: • Build capacity of general practice to improve physical health of people with mental illness. • Work with mental health providers to support their	Workforce development	ACT PHN

		Stakeholders stated that mental health consumers with financial barriers to gaining treatment experience barriers to accessing GPs and being able to pay for prescriptions and tests. Stakeholders highlighted the need for mental health screening for people with chronic conditions and disabilities, as 49% of people with disabilities have a mental health condition.		clients in accessing care for physical health needs. • Support activities that increase health literacy and build capacity of consumers to navigate complex health needs. • Work collaboratively with ACT Health and Canberra Health Services to scope models of care		
	4.3 Need for increased awareness of the stepped care model available in the ACT, allowing increased access to well-informed mental health providers	Stakeholders highlighted the need for better primary mental health care services, following a stepped care model with low intensity through to high intensity services, highlighting the following gaps: • Services focusing on psychological interventions for people with moderate to severe presentations, who require more than 10-12 sessions with a mental health clinician in a calendar year. • Psychological interventions that are not CBT based, for people who do not respond well to CBT but respond well to other models such as Solution-Focused Therapy or Motivational Interviewing. Stakeholders highlighted a need for better integration between primary mental health care services and tertiary services and stepping up and down between these, and for these services to have a holistic whole of person focus. Stakeholders identified the need for services to upload information to My Health Record so mental health consumers can easily share their information, however, there is often concern from mental health consumers that they may be stigmatised by health services if they are aware of their mental health condition, rather than being treated for their other condition(s), e.g. physical health.	Consumers and primary health care professionals are supported to understand appropriate assessment, management, and service options for mental health concerns. Improved transition between primary and secondary/tertiary services. Improved client outcomes including achieving recovery in the current episode of care.	Facilitate sector-wide collaboration to support a responsive, accessible sector: • Continue collaboration with Canberra Health Services around integrating intake services and developing clear referrals pathways and shared care between services (i.e. primary, secondary and tertiary care). • Ensure availability of services across the lifespan and stepped care continuum by commissioning services where there are gaps. • Engage consumers in designing client-centred services • Support activities that increase health literacy and build capacity of clients to navigate complex health needs. • Optimise use of My Health Record among mental health clinicians and collaborate with consumer groups to address concerns around privacy.	Workforce development Strategic Relationships	ACT PHN
	4.4 A range of service delivery gaps for people who are not accessing the NDIS.	With the commencement of the Psychosocial Disability component of the NDIS in the ACT, stakeholders have expressed uncertainty in regards to future system capacity to support those who are eligible for Psychosocial Disability Packages of care through the NDIS and for those who are not. Concerns include: • The need for a continuing care coordination service for those with severe mental ill health who do not transition to the NDIS. • The need for GPs to be educated around the NDIS, including provision of documentation for package planning.	Access to psychosocial support services.	Support the sector to understand and address changes in psychosocial services for people with severe mental illness. • Work in partnership with ACT Health to co-commission and evaluate psychosocial services for people with severe and complex mental illness	Procurement Workforce development	ACT PHN

		• Lack of specific skills in working with NDIS clients, in particular when clients experience comorbid developmental disability and mental health issues. • Lack of support services and psychosocial rehabilitation for people with packages. • Poor delineation between federally funded and territory funded programs was identified by stakeholders, who feel that there is not a coordinated response in the ACT. • Future system capacity to support both those who are eligible for Psychosocial Disability Packages of care through the NDIS and those who are not. • The NDIS does not deliver the intensity or range of supports available through previous mental health programs, including in the area of psychosocial rehabilitation. • Need for continued access to a range of supports, including care coordination services, for those with severe mental ill health who do not transition to the NDIS. This includes current service participants as well as those yet to develop the need to access services. A number of community-managed mental health services and programs have now ceased to exist. Stakeholders identified the following gaps: • Psychosocial rehabilitation services • Peer support and mentoring • Medium term high intensity daily living supports and capacity-building • Low intensity daily living supports and capacity-building (for sustained and continuing recovery) • Recovery-oriented independent living supports • Recovery-oriented recreational & social supports, including group programs • Care coordination services • Mental health specific employment support services • Vocational rehabilitation and training • Support for carers who are navigating a new system		who are not accessing NDIS in alignment with the Recovery Oriented Framework. • Support primary health care providers to navigate the NDIS and other services available to clients. • Support activities that increase health literacy and build capacity of consumers to navigate complex health needs. • Continue collaborating with community managed mental health services to understand gaps and identify and scope solutions.		
	4.5 Need for increased access to culturally-appropriate mental health services for LGBTIQ persons, refugees, CALD populations, and other diverse groups.	Evidence suggests that vulnerable groups experience higher rates of mental ill health. Stakeholders have highlighted the following areas of need: • An increase in the provision of specialist psychiatric support for Transgender population • Increased social awareness for the general community to reduce the stigma for LGBTI communities • Need for more training and support in trauma informed care for mental health professionals to work effectively with vulnerable populations • Connection and referral between other services. Stakeholders particularly identified this as a need for transgender people • Improved accessibility and provision of mental health services for people who are at risk of homelessness or who are homeless • An emphasis on stabilising mental health conditions in people who have severe substance use issues, rather than waiting to receive treatment for substance issues first. • An increase in the provision and knowledge of specialised mental health services for refugees, particularly in regards to trauma informed care • Lack of information on and access to bilingual GPs and health professionals • Lack of mental health expertise interpreters, as well as poor continuity in the provision of interpreter services.	People from diversity groups have improved access to appropriate and responsive mental health services.	Ensure access to diversity groups by: • Evaluating existing services to ensure equitable access • Provide support and capacity building to existing services to provide more culturally responsive care through education, quality improvement initiatives, and targeted promotion of services. • Leverage existing relationships with community groups to promote services among target populations.	Procurement Workforce development	ACT PHN

	4.6 Low awareness and subsequent uptake of existing suicide prevention services in the ACT	There is currently a perceived lack of support and primary mental health care services for suicide prevention in the ACT. Stakeholders highlighted the following areas of need: • Improved support services for people discharged from hospital following a suicide attempt or suicidal crisis • Promotion of the National telephone service called Suicide Call Back Service for people who are suicidal • Improved screening of individuals accessing primary care services, including seeing their GP • Increased access to primary mental health care services for people with suicidal ideation • Increased understanding of referral pathways for people with suicidal ideation who are not at immediate risk of self-harm • Improved ease of access to primary mental health care services and community based services for people with suicidal ideation, for example, self-referral • Support for families of those struggling with suicidal ideation who are often utilised as the safety plan but don't have support in how to do this or access to emotional support in a timely manner • Development of additional post-vention services and intervention services	The ACT has an integrated approach to suicide prevention.	Collaborate with ACT Health to deliver a system-wide approach to suicide prevention, through implementation of the Lifespan program, that includes: • primary care, acute services, community sector • co-commissioning services • community engagement • Cross sector collaboration with social services, education and other relevant areas	Strategic relationship Procurement	ACT PHN
	4.7 Lack of peer participation and consumer involvement in the design of services in the ACT	People with lived experience of mental illness offer perspectives that enrich how services are delivered. Stakeholders stated that there is a lack of peer participation in primary mental health in all phases of commissioning. In addition to this, stakeholders acknowledged that there is a lack of peer led service models and funding to develop these.	People with lived experience are included as equals in all planning and phases of commissioning. Increased access to peer-led services	Expand roles and opportunities for peer workforce in the ACT by: • Researching, scoping and procuring peer-led service models • Continue to ensure participation of peer workforce in commissioning activities including consumer-led co-design • Develop activities to build capacity of existing peer workers.	Procurement	ACT PHN
	4.8 Increasing rates of mental ill health in children and adolescents in the ACT	Data suggests that the prevalence of mental health disorders in Australian young people and their use of services for these problems has significantly increased between 1998 and 2013-14. These mental health disorders can impact on functioning at school, with family and friends and cause? personal distress symptoms. Adolescents are almost three times more likely to experience a severe mental health disorder compared with 4-11 year olds. There has been an increase in the number of children (0-12 years) referred to early intervention programs in the ACT. ACT has the highest dispensing rate of antidepressants in Australia, for adolescents up to 17 years.	Access to child and youth-specific mental health services. Primary health care professionals feel supported to assess, manage, and refer children and young people with mental health concerns.	Continue to commission mental health services that support 0-12 year olds and their families. Continue to commission mental health services for 12 to 25 year olds, including headspace and high intensity psychological intervention services. Engage with relevant stakeholders to ensure integration of existing services including ACT Health, ACT Education and Training Directorate and ACT Community Services Directorate.	Procurement Strategic relationships	ACT PHN

	4.9 Access to psychology services for children and adolescents.	Access to mental health services is one of the biggest issues faced by children and youth in the ACT, in particular vulnerable children such as those in out-of-home-care and child protection. It is the biggest issue faced by vulnerable children in Tuggeranong. There are long waiting lists for counselling services even though there are many programs running (particularly through Child and Family Centres). Many of the programs run within the ACT use family based therapy models which excludes a number of children who don't have family members in a position to complete therapy together (i.e. children in out-of-home-care). There is a lack of service availability for children with mental health issues (and their parents). This includes psychologists as well as community-run mental health assistance. People are being discharged from the mental health unit into the community with no follow-up. Using CBT as the preferred counselling model is an obstacle to recovery for those children who do not respond well to this model. Others models such as Motivational Interviewing need to be used to produce more effective results.	Access to child and youth-specific mental health services. Primary health care professionals feel supported to assess, manage and refer children and young people with mental health concerns.	Continue to commission mental health services that support 0-12 year olds and their families. Continue to commission mental health services for 12 to 25 year olds, including headspace and high intensity psychological intervention services. Engage with relevant stakeholders to ensure integration of existing services including Canberra Health Services, ACT Education and Training Directorate and ACT Community Services Directorate.	Procurement Strategic relationships	ACT PHN
	4.10 Identification of children in their middle years in primary health care.	Primary health care professionals need to be aware of issues that are associated with children in their middle years, including the challenges that puberty and transitioning to high school can bring. Young people in marginalised groups are at higher risk of poor wellbeing. This includes young people with a disability; LGBTIQ; carers; Indigenous; culturally and linguistically diverse; those who are materially disadvantaged; and young people in out-of-home care. Early identification of mental health issues and healthy growth and development are the most important issues in this period of childhood.	Access to child and youth-specific mental health services. Primary health care professionals feel supported to assess, manage, and refer children and young people with mental health concerns.	Support primary health care professionals to provide appropriate and responsive care to children and young people in marginalised groups including: • Identification of risks and concerns • Understanding resources available and programs tailored for specific groups. Engage with relevant stakeholders to ensure integration of existing services including ACT Health, ACT Education and Training Directorate, ACT Community Services Directorate.	Workforce development Strategic relationships	ACT PHN

5. Alcohol & Other Drugs	5.1 Timely access to AOD services to enable more effective treatment	Relatively rapid change in ACT drug trends are consistent with national trends ((360Edge and Alcohol Tobacco and Other Drug Association (ATODA), 2017) referencing (Australian Institute of Health and Welfare, 2017)). Increased AOD related harms including e.g.: • Rates almost doubling for people who are dependent drug users (i.e. methamphetamine) over a relatively short period (3 years) ((360Edge and Alcohol Tobacco and Other Drug Association (ATODA), 2017) referencing (Dietze, 2016)). • Increased demand on specialist AOD treatment and support services (e.g. increased presentations to specialist AOD services where amphetamines is a drug of concern) ((360Edge and Alcohol Tobacco and Other Drug Association (ATODA), 2017) referencing (Ritter, et al., 2014)). • ACT opioid overdose rates highest in 10 years (Penington Institute , 2018). 36% increase in demand for specialist AOD non-government services from 2010-2014 (360Edge and Alcohol Tobacco and Other Drug Association (ATODA), 2017). Lack of dosing pharmacists in the ACT - many people using opioid replacement therapy have to travel significant distance in the ACT for dosing. This is especially difficult on weekends when public bus services are reduced. Harm reduction services have a strong evidence base and have been used effectively in the ACT, including peer based approaches. Sustained positive AOD treatment outcomes over the longer term are more common for those who have experienced severe and complex AOD problems with longer treatment duration and more intensive treatment modalities. If people who need AOD treatment don't get a specialist AOD response when they seek it they may not re-engage for significant periods of time and may remain at high risk. Current ACT AOD treatment population experiencing significant complexity (e.g. 70% unemployment) (Service User Satisfaction and Outcomes Survey, 2015). 25% of the current ACT AOD treatment population identify as Aboriginal and Torres Strait Islander (Service User Satisfaction and Outcomes Survey, 2015).	Access to AOD services.	Increase the capacity of the AOD sector through: • Continue commissioning services to fill gaps in existing service landscape • Monitor and map current service usage data to understand where there are pinch-points and changes in service utilisation • Ensure an integrated approach through capacity building and stakeholder engagement that includes general practice, pharmacy and specialist services • Promote service models that include informed decision making & building capacity of clients in alignment with recovery oriented frameworks.	Procurement Workforce development	ACT PHN
	5.2 High rates of AOD related issues amongst Aboriginal & Torres Strait Islander persons	Disproportionate burden of alcohol and other drug related harms experienced by Aboriginal and Torres Strait Islander people in the ACT region. A national survey of Aboriginal and Torres Strait Islander community controlled services and AOD services reported that 79% of respondents identified methamphetamines as a significant issue for Aboriginal and Torres Strait Islander clients. The ACT Aboriginal Community Controlled Health Organisation (ACCHO) reported that over the last two years there has been a significant increase in the use of methamphetamine, with an increase in presentations at the ACCHO. An Aboriginal and Torres Strait Islander youth based service in the ACT reported an increase in methamphetamine use in the youth community, which also has a broader impact on family members. The youth service has identified that their workers are not appropriately trained to support clients using methamphetamine and their families. They also identified that there were a lack of culturally appropriate methamphetamine and broader AOD related resources to provide to clients.	Access to culturally appropriate AOD services. Improved consumer experience of AOD services.	Continue to commission specific services for Aboriginal and Torres Strait Islander people and their families. Facilitate integration of Aboriginal and Torres Strait Islander Mental Health Services and AOD services. Develop a Cultural Safety Framework for commissioned providers.	Procurement	ACT PHN

	5.3 Support needed for GPs and other primary care professionals in management of patients presenting with AOD misuse	GPs and mental health professionals participating in consultations and completing education evaluation forms have highlighted the need for support and resources relating to assessment and management of drug and alcohol use within primary care. In particular, GPs and mental health professionals have identified the need for education to have a focus on assessment tools and evidence based interventions, and for supporting resources to be provided including clear referral pathways. Stakeholder feedback highlighted that tobacco remains a persistent community health issue, particularly for new arrivals, refugees and Aboriginal and Torres Strait Islander groups. E-cigarettes are also an issue.	Primary health care professionals feel supported to identify, manage and refer patients with AOD concerns.	Continue to support the workforce capability of primary health care professionals through: • Education and training focusing on assessment and management within primary care • Promoting HealthPathways to support appropriate referrals.	Workforce development	ACT PHN
6. Chronic Conditions	6.1 Low levels of self-care and self-management by consumers who have chronic conditions	Patient activation through enhanced health literacy is considered a primary preventative and quality and safety measure (NSQSH). 60% of Australians aged 15–74 years do not have adequate health literacy (circa 45% of ACT pop). Low health literacy is associated with less healthy behaviours and poorer health status, higher rates of PHC utilisation, avoidable ED presentations and hospitalisation and increased health care cost. Tailoring patient care in line with their measure of activation to improve their health and lifestyle can be used to reduce health inequalities and deliver improved outcomes, better quality care and lower costs. Patient activation measurement and tailored health literacy and self-management initiatives in the ACT are limited. An evaluation of the former HCCA Health Literacy for All program demonstrated greater understanding of health system and a 71% increase in confidence to self-manage personal and family health. The ACT has a range of self-management and health coaching (i.e. behaviour change) and supported decision making programs for people with chronic conditions and disability spanning public and private health systems. However: • There is limited awareness of these amongst consumers and clinicians • Eligibility criteria and access routes are unclear • Programs are not integrated into care planning nor health pathways.	Consumers are enabled to engage in health care decision making and self-management.	Better targeted services for people with chronic disease by utilising general practice data to inform: • Identify high risk or rising risk patients • Identify and trial a risk identification tool • Implementation of a patient activation screening tool and measure • Promote QI PIP program • Trial alternative funding model to nurse-led chronic disease management • Scope and trial models of team based care • Deliver health literacy initiatives.	Workforce development Procurement	ACT PHN
	6.2 Support for the development and use of whole-of-person, multidisciplinary care models	Advanced or high performing general practice is the foundation of an effective and efficient health care system. Evidence confirms that patient centred medical home initiatives have the potential to: increase consumer satisfaction and health outcomes; reduce health care costs associated with unnecessary use of ED, hospital and specialist services. Noting that most frequent avoidable ED presentations and hospital admissions relate to diabetes, heart disease, COPD and mental illness. The QiData initiative strengthens the ability of general practice to identify those at risk of poor health outcomes and enhance quality and safety through appropriate call/recall (i.e. CD screening, assessment and management) capability.	Primary health care professionals feel supported to deliver patient-centred, team-based care. Access to multidisciplinary care.	Continue to build the capacity of general practice to adopt the principles and practices of high-performing primary care through • Education • QI activities Identifying, scoping and implementing multidisciplinary models of care.	Workforce development Procurement	ACT PHN
	6.3 Low rates of shared and coordinated care for patients with chronic disease	12.9% of GP-attenders are responsible for 41% of Medicare expenditure. High users tend to have more chronic conditions, lower levels of health literacy and greater levels of disadvantage than low-attenders and they need multi-disciplinary and coordinated care to address health needs.	Healthcare providers to use digital health systems to improve patient care and communication.	Improve access to coordinated and multidisciplinary care through: • Identify high risk or rising risk patients • Identify and trial a risk identification tool • Scope and trial models of team based care	Workforce development Strategic relationships Procurement	ACT PHN

<table>
<tr><td></td><td></td><td>In 2017-18, ACT had approximately half the national services per 100,000 population for Medicare GP Management Plans (GPMPs) (54%) and Team Care Arrangements (TCAs) (51%) and review of GPMP/TCA (49%) was the lowest rate in Australia.
Chronic Disease Management podiatry and physio referrals are at 23% and 32% of the national per capita rate.
Chronic disease management is complex and multifaceted: many consumers requiring multiple, contingent and/or complementary services, spanning a complex and disconnected health system.
Health systems are stronger if they are more comprehensive, coordinated, community focused, universal, affordable and person/family oriented:
- Both shared care and care co-ordination are critical components of all best practice chronic care arrangements and advanced primary health care.
- A consistent approach to clinical care protocols and pathways for specific chronic diseases can make a real difference to health outcomes (e.g. Heart Failure and Respiratory Disease)
- Responsive step up/step down capability spanning primary care, community health, sub-acute, acute and specialist services achieve better health outcomes
- Digital technology, electronic health records and information sharing tools are key system enablers - enhancing service quality and safety, reducing duplication and waste
Person focused and integrated care spans holistic health and social care needs of individuals</td><td></td><td>- Deliver health literacy initiatives
- Collaborate with specialist services and ACT Health to improve communication and sharing of clinical care.</td><td></td><td></td></tr>
<tr><td></td><td>6.4 Need for greater focus on prevention</td><td><table>
<tr><th>Disease group</th><th>Years of Life lost</th><th>Chronic Diseases as a %</th></tr>
<tr><td>Cancer & other neoplasms</td><td>9,223</td><td>34%</td></tr>
<tr><td>Cardiovascular diseases</td><td>5,605</td><td>21%</td></tr>
<tr><td>Injuries</td><td>3,810</td><td>14%</td></tr>
<tr><td>Neurological conditions</td><td>2,290</td><td>8%</td></tr>
<tr><td>Infant & congenital conditions</td><td>1,349</td><td>5%</td></tr>
<tr><td>Respiratory diseases</td><td>1,306</td><td>5%</td></tr>
<tr><td>Gastrointestinal diseases</td><td>1,277</td><td>5%</td></tr>
<tr><td>Infectious diseases</td><td>519</td><td>2%</td></tr>
<tr><td>Endocrine disorders</td><td>490</td><td>2%</td></tr>
<tr><td>Kidney & urinary diseases</td><td>446</td><td>2%</td></tr>
<tr><td>Blood & metabolic disorders</td><td>359</td><td>1%</td></tr>
<tr><td>Mental & substance use disorders</td><td>294</td><td>1%</td></tr>
<tr><td>Musculoskeletal conditions</td><td>258</td><td>1%</td></tr>
</table>In 2011, Chronic diseases accounted for over 75% of the years of life lost from all diseases/injuries in the ACT. Much of the burden could be prevented by removing exposure to risk factors such as tobacco use, high body mass, alcohol use, physical inactivity and high blood pressure.</td><td>Primary health care professionals are supported to undertake preventative health initiatives.
Improved patient enablement and engagement in health care decision making and self-management.
General practices and other health care providers use data to improve care.</td><td>Build workforce capacity of general practice to engage in preventative activities through:
- Education and training
- Quality improvement initiatives
- Scope health literacy initiatives
- Promote HealthPathways.
Collaboration with ACT Health around ACT's Preventative Health Strategy.</td><td>Workforce development
Strategic relationships</td><td>ACT PHN</td></tr>
</table>

	6.5 Access to information and resources about managing chronic pain in the community	Chronic pain is pain that lasts beyond the time expected for healing following surgery or trauma or other condition. It can also exist without a clear reason at all and is a symptom of an underlying health issue. Approximately one in five Australians suffer chronic pain, with the prevalence rising to one in three in people aged 65 years and over. It is more common with increasing age, with prevalence peaking in the 65-69 year age group for males and in the 80-84 year age group for females. Women are more likely to experience pain than men. Chronic pain is strongly associated with: - increased hospitalisation and a high level of GP visits and ED presentations - markers of disadvantage - treatment and management options need to be affordable. Some forms of chronic pain (e.g. pain associated with severe osteoarthritis) may be treated with therapy which may include medication or surgery; however, other types of chronic pain, such as neuropathic pain or migraine, may be far more difficult to diagnose and treat. The vast majority of people living with chronic pain can be managed in the community if appropriate and timely diagnostics, services and supports are provided in primary health and community settings. The predominant model of care is specialist-focused with pain management services centralised in the Canberra Hospital setting. There is currently a significant wait for specialist services (above the recommended wait times) and an increasing demand for services. Feedback from consultation suggests the current model of care is unsustainable and consideration should be given to alternative primary care and community based approaches, integrated and team based, multidisciplinary, holistic models of care. GPs play a fundamental role in the diagnosis and management of chronic pain and practice nurses have a key role in ongoing management and care coordination. Consultation suggests that GPs and other primary health practitioners would benefit from enhanced education and capacity building opportunities. Chronic pain medication needs better management around long-term health / impacts of prolonged use If pain cannot be managed in a primary health care setting, specialist services may be warranted. Whilst multiple HealthPathways have been developed, consultation suggests that there appears to be limited knowledge and application of these. Determining which specialist or service to refer to can often be challenging, however if applied, HealthPathways could be utilised to inform clinical decision making, enhance the quality of referrals and accelerate referral processes.	Primary care health professionals feel supported to manage chronic pain in the community and utilise appropriate referral pathways. Improved outcomes for people experiencing chronic pain.	Support general practice to better manage chronic pain in the community through • Improving workforce capability • Research and scope models of care for community-based pain management including mapping of current availability and alternative approaches • Promote HealthPathways • Integrate with QI initiatives.	Workforce development	ACT PHN

7. Aged Care	7.1 Lack of access to primary care for residents in RACFs	Older people constitute around 36% of hospital separations and 18% of ED presentations and per capita hospitalisation rates have increased by 23% and ED presentation rates by 14% over a decade. Older people are more likely to: • Be admitted to hospital with existing health or community services needs or require step-down to these services on discharge • Experience delayed transfers of care • Report uncertainty, lack of confidence and lack of support on discharge from hospital • Be at high risk of re-admission because of their complex needs and frailty. Between 2004-2013, the proportion and rate of ED presentations for older persons in the ACT increased by 14.4%, with the increase driven by those 85 years and over. Some older patients have spent over a year in ACT hospitals. Some of this has been attributed to the lack of adequately resourced RACFs capable of administering continuous morphine infusions. ED is a challenging environment for older people, particularly those with dementia. RACF residents are a particularly vulnerable group. Dementia is the second leading cause of death for people over 65 in Australia. Half of all permanent residents of aged care facilities in the ACT have a diagnosis of dementia. In 2015/16 there were 2,531 hospital separations for ACT residents that involved a diagnosis of dementia. The AMA published an article 'A Crisis in Aged Care looming' noting the declining number of GPs attending appointments in RACFs and a lack of access to GPs for residents of RACFs. RACFs report significant issues around discharge processes from EDs and acute wards. Lack of timely access has consequences for not only the older person, their family and RACF staff but also for the ED and hospital system. My Health Record access would help close gaps in RACFs but most facilities are not connected to and using the system. Ready access to a GP once a person enters residential aged care was identified as a priority area for action by the GP Taskforce in 2009 and still remains a significant issue. Only a small number of the ACT's residential aged care facilities have adequate GP coverage, and this is usually the result of an in-house GP arrangement or an arrangement with a local multiple GP practice. When the health or independence of an older person deteriorates rapidly they should have access to rapid urgent care, including effective alternatives to hospital. The lack of an accessible GP is often the cause of referral to ED as an alternative, and many cases an inappropriate one. Similarly, there are significant barriers and gaps with regard to accessing psychology and other allied health services.	Access to primary care services including mental health services for people in the aged care system.	Support integration and information sharing between RACFs and general practice. Continue commissioning services that provide clinical support to RACFs and a point of liaison between GPs, RACFs and acute services for acutely unwell residents. Disseminate learnings and develop business cases for service models in the ACT. Improve engagement in My Health Record in RACFs for information sharing. Scope and commission primary mental health services for RACFs. Research and scope opportunities to collaborate with home-based aged care services.	Procurement Workforce development Strategic relationships	ACT PHN
	7.2. Medication management and support for older people in the ACT, through GPs,	Older people are more at risk of experiencing side effects from their medicines. They may also experience difficulties with vision, hearing, memory or cognitive functions that can make managing medicines safely a lot harder. Approximately 50% of patients don't take their medication as prescribed by their healthcare professional. This medication non-adherence compromises the	Access to education to primary health care professionals and RACF staff about medication management.	Continue support medication management through: • Delivery of the Pharmacy in general practice service • Palliative Care Medication Pilot.	Procurement Workforce development	ACT PHN

	community pharmacy or in-place RACF staff	effectiveness of treatments, increases the risk of medication incidents, and reduces health gain and quality of life. There is a greater need for titration of medicines for those people with comorbidity who have complex pharmaceutical regimens. There is also limited knowledge and understanding about the ongoing interface and interaction between medications and nutrition. RACFs that adopt the use of My Health Record may see a number of benefits from accessing a person's health status, current medicines information and timely access to documents such as hospital discharge summaries, allergy and adverse reactions and immunisation status.	Improved health literacy for consumers about medication management.	• Scoping service models for RACFs.		
	7.3 Need for greater communication and awareness of end of life choices and management	It is widely accepted that hospitals remain the last preferred place of death but still remain the most common places to die, with many people being actively treated right up to the moment of their death, in some cases involving expensive and futile treatment. A project by Palliative Care ACT and ACT Health found 71% of all respondents wished to die at home, with medical communities perceived by respondents to lack acknowledgement of end of life support services such as palliative care, reflected by the reticence of general practitioners and specialists in discussing and referring patients to end of life care. Many of the problems associated with the effective provision of end of life care relate to barriers that occur at the interfaces between settings, services and health care professionals. Advance Care Planning should be a part of routine health care and GPs can play a guiding role in this process. Consultation highlighted the need for more effective doctor-patient communication, which is likely to have specific benefit such as patients being more likely to adhere to treatment, have better outcomes and express greater satisfaction with treatment. Education for families, carers and RACF staff in end of life care and support during difficult times, has also been raised by stakeholders.	Increased awareness of end-of-life care planning and options. Improved rates of people dying in their place of choice.	Support primary care clinicians to engage patients and carers in early conversations about end-of-life care planning and Advanced Care Directives through: • Education and training • Promoting HealthPathways Investigate the introduction of a systematic approach for RACFs in the ACT with a view of establishing a comprehensive programs. Support the utilisation of My Health Record to document advanced care plans and facilitate communication and collaboration between all end-of-life care providers include pharmacy, Palliative Care Services, general practice, families and carers. Advocate for a Compassionate Communities approach that orients care toward the integration of community based networks and support structures.	Workforce development Strategic Relationships	ACT PHN/ ACT Health
8. Workforce	8.1 Supporting a sustainable primary health care workforce	An ageing population, marked increase in chronic diseases, increased use of telemedicine and more informed consumers are changing the nature of primary care. Other workforce concerns include: • Increased need for team based care and care coordination. • Fall in average hours worked by GPs and increased female workforce participation. • Increased pressure on practices for training places for medicine, nursing and allied health disciplines. • Lack of a structured program to support graduate nurses entering general practice.	Increased opportunities for primary care professionals to upskill and build capacity. Increased opportunities for inter-disciplinary learning and collaboration.	Support a sustainable primary care workforce through delivery of specific training and support initiatives for Practice Nurses including • Introduction to General Practice • Collaboration with ACT Health Nursing and Midwifery Office to support general practice nurses in upskilling through	Workforce development	ACT PHN

		- Lack of support to coordinate allied health student placements in ACT practices. - Limitations to GP infrastructure to accommodate growing team numbers. - Uneven distribution of the GP workforce. Move towards health care homes / patient centred medical homes will require new roles (e.g. Medical Assistants) and redefinition and rethinking of existing roles (e.g. expanded role for Practice Nurses).		rotations in acute and specialist services. - Ongoing education and networking opportunities. Engage with local Universities to facilitate clinical placements and learning opportunities for students.		
	8.2 Lack of multi-disciplinary primary care team models.	There is a growing burden of chronic disease in the ACT which has resulted in an increasing role for general practitioners in conjunction with other health care practitioners to deliver multidisciplinary team based care. Multidisciplinary care provides a more diverse range of skills and experience than care delivered by a single provider and its importance in chronic care has been well established. The multidisciplinary team requires specific skills in coordination and continuity of care and clinical team leadership, in order to meet the comprehensive needs of patients with chronic and complex conditions. Anecdotal feedback reports that there is a need for better coordination and communication between general practice and allied health providers, in particular relating to chronic disease care plans. The very low rate of chronic disease management item numbers, including Team Care Arrangements, claimed in the ACT, indicates that there is a need to improve integration and communication between general practices and allied health.	Increased capacity for primary care to respond to growing demand and increasing rates of chronic disease.	Scope models for multidisciplinary care based on the principles of high-performing primary care including training and upskilling of workforce or introduction of new workforce including medical assistants or peer-workforce for mental health. Support integration of services across the continuum and GPs to utilise: - Team Care Arrangements - Chronic Disease Management billing codes - QI PIP.	Workforce development	ACT PHN
9. Vulnerable and at-risk Groups	9.1 People who are homeless or at risk of being homeless miss out on primary care services due to lack of regular GP or place of care, and ability to access services	**People who are homeless or at risk of being homeless** Homeless people encounter substantial barriers to accessing mainstream primary health care services, including long waiting times, inflexible scheduling, inadequate service options, lack of transport, lack of finances, lack of a fixed permanent address (e.g. for appointment letters) and potentially cognitive impairment such as poor memory. This isn't only an issue for accessing a GP, but also psychological services, other allied health and specialists. Poor access can lead to delayed clinical presentation, increased reliance on emergency departments and higher rates of hospitalisation, often for preventable conditions.	People that are homeless or at risk of homelessness can access high quality primary health care services.	Continue delivering in-reach clinics and services targeting this cohort. Assess current services to determine current level of service provision to people who are at risk of homelessness and identify areas for improvement.	Procurement	ACT PHN in partnership with the Early Morning Centre
	9.2 More support and advice for primary care and other professionals in identifying and managing patients experiencing domestic or family violence.	**People experiencing domestic and family violence** According to the ABS Personal Safety Survey 2016, in the 12 months prior to the survey, around 7,700 ACT women had experienced some form of violence; 5,800 had experienced physical violence and 1,900 had experienced sexual violence. Key themes in the Domestic Violence Prevention Council Report (2015): - clinicians can miss domestic violence as they tend to be very focused on symptoms and interventions and some clinicians are hesitant about asking questions as they are unsure about what they can do and to whom they can refer - there is a need for information on domestic violence and skills development on how to talk to clients, how far to go to elicit more information, what to do with disclosures, when to refer, who to refer to and how far to go with the client.	Primary care providers feel supported to identify, manage and refer people experiencing violence. Primary health care professionals have improved knowledge, confidence and resources to support patients experiencing family and domestic violence.	Collaborate with ACT Government's Safer Families initiative in a multi-sector initiative to prevent and support people experiencing family and domestic violence. The role of the PHN might include: - Continued promotion of localised HealthPathways that include both health and social services. - Piloting and testing a universal screening program in general practice - Providing in-reach clinics to refuges or other	Strategic relationships Workforce development	ACT PHN in partnership with the Women's Centre for Health Matters and ACT Government

				organisations serving this population. Assess current services to determine current level of service provision to people who are at risk of homelessness and identify areas for improvement.		
	9.3 Awareness and ongoing reinforcement of appropriate use of interpreters to deliver quality care for patients from CALD communities	**CALD populations / Refugees** Use of interpreters is essential in facilitating access to care and delivering quality of care. Low levels of English proficiency and access to qualified interpreters is a systemic problem compounded by providers reluctant to use interpreter services and/or insufficient interpreters for certain language groups. Language barriers impede access to healthcare, including mental health care, which can compromise quality of care and may increase the risk of adverse health outcomes among patients with limited English proficiency. A culturally competent health care system is essential to improved health literacy in CALD communities.	Primary health care providers are aware and able to access interpreter services.	Develop a communication strategy to inform GPs of TIS services, procedures, risks and benefits including promotion of HealthPathways Interpreter Services information.	Workforce development	ACT PHN in partnership with ACT Health Care Consumers Association
	9.4 Lack of culturally appropriate resources and information to support patient enablement and health literacy	**CALD populations / Refugees** A culturally competent health care system is essential to improved health literacy in CALD communities. People with inadequate health literacy have limited ability to search for and use health information, make informed decisions or maintain their basic health. Research demonstrates that there are strong correlations between low health literacy and less healthy behaviours, poorer self-management of chronic conditions, higher rates of hospitalisation, difficulty communicating with providers and poorer health status in general. Language barriers impede access to healthcare, can compromise quality of care and may increase the risk of adverse health outcomes among patients with limited English proficiency.	People from CALD communities and refugees have increased access to health information.	Collaborate with consumer and community groups to promote health literacy. Scope models for local education and activation. Promote access to information in various languages and using alternate formats such as audio, video, utilising pictures instead of lengthy written documents.	Strategic relationships Workforce development	ACT PHN in partnership with ACT Health Care Consumers Association
	9.5 Access to safe and supportive health services for the LGBTIQ community	**Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) population** Consultation undertaken by ACT Health Care Consumers' Association in 2013 highlighted that the search for an appropriate GP becomes crucial for LGBTIQ consumers as the GP needs to possess both adequate knowledge and sensitivity to assist them in treating/managing and navigating through the system. Consumers stated that for transgender people, the GP is the gatekeeper to the very first elements of their transition, usually access to hormone therapy. Consultation with general practitioners highlighted a lack of referral options and other support services available locally to support holistic care.	People that identify as LGBTIQ are supported to access appropriate services and health information. Primary health care professionals feel supported to manage and refer patients that identify as LGBTIQ.	Provide education and capacity building opportunities for primary health care professionals to work with LGBTIQ clients in a way that is sensitive and appropriate. Map gaps in services and explore opportunities to develop: • Shared care models • Opportunities for integration and improved communication • Facilitating access to limited services.	Workforce development	ACT PHN with the LGBTIQ Community Consortium

	9.6 Barriers to accessing a primary care provider upon release, increasing the risk of poorer health status	**People exiting prison** People in prison experience increased rates of mental illness, substance abuse and chronic and infectious disease. These populations are also frequently adversely affected by socioeconomic risk factors for poor health, including lower educational attainment and higher rates of poverty. Given this, such populations are in clear need of significant health services. Particularly upon release from prison, former inmates may require substantial assistance in securing health care access. In the ACT, a lack of bulk-billing GPs creates a barrier for this population, as well as transportation and location of services, which can limit access to health facilities. Accessing health care post-imprisonment requires reapplying for a Medicare number as Medicare cards are frozen when a person enters prison. This creates an additional barrier to addressing health issues while managing competing priorities of re-establishing housing, employment and relationships with family and community.	People exiting prison are better connected to primary care services upon release.	Ensure people exiting prison are supported to access primary health care by: • Promoting the utilisation of My Health Record as a way of ensuring critical health information is transitioned with the person as they exit prison. • Scope models of care to support health during transition integrated with existing through care services and social supports.	Workforce development	ACT PHN
	9.7 Access to testing and treatment of hepatitis B and C	**People living with blood-borne viruses** Hepatitis C virus (HCV) and hepatitis B virus (HBV) are strongly linked with liver cancer, which is the only common cancer where mortality rates have increased between 1982-2017. The number of people living with chronic hepatitis C in the ACT in 2016 has been estimated at approximately 3,600. There is no vaccine for hepatitis C and previous infection does not provide immunity to reinfection. However, new direct-acting antiviral (DAA) treatments for hepatitis C, with a cure rate around 95%, are now available on the Pharmaceutical Benefits Scheme (PBS) and have become more accessible to people living with hepatitis C in Australia. Data suggest the ACT has a much higher rate of specialist DAA treatment compared to GP treatment, than the rest of Australia. Hepatitis B disproportionately affects often already marginalised populations such as migrant communities, Aboriginal and Torres Strait Islander people, people with a history of injecting drug use and men who have sex with men. Hepatitis B is under-diagnosed and under-treated, with estimates that approximately 38% of people chronically infected with hepatitis B are undiagnosed, and only 6.4% in the ACT are receiving treatment for their condition (national average 7.2%). The prevalence is 4,036 (0.98% - the same as the national average). Timely diagnosis and clinical management, including antiviral therapy, can prevent chronic hepatitis B related deaths from cirrhosis and liver cancer.	Primary health care professionals feel supported to identify risk, and deliver prevention, assessment, and management of hepatitis B and C. Improved access to prevention (i.e. vaccines) and timely treatment and counselling.	Build capacity of the primary care workforce by: • Providing ongoing training and education to deliver prevention detection and treatment services for people with hepatitis B and C. • Promote free hepatitis B vaccines for eligible at-risk populations • Promote HealthPathways.	Workforce development	ACT PHN
	9.8 Access to testing and treatment for HIV	**People living with blood-borne viruses** Data from the 2016 Annual Surveillance reported that about 10% of the estimated 25, 313 people living with HIV were unaware of their HIV-positive status. About half of all people living with HIV in Australia are managed predominantly by GPs. GPs play a vital role in HIV care, particularly in early diagnosis and support of patients to remain in long-term care. Early diagnosis of HIV infection is important so that patients can be offered timely monitoring and treatment to prevent immune suppression and resulting complications. As well as the individual benefits of early treatment, the reduced risk of transmission of HIV to sexual partners is an additional consideration. People living with HIV will require regular and consistent monitoring throughout their lives. Patient education, support and adherence to treatments should be encouraged and provided at every monitoring visit.	Increased HIV testing in the community and timely access to treatment and counselling.	Build capacity of the primary care workforce by: • Providing ongoing training and education to deliver prevention, detection and treatment services • Promote HealthPathways • Increase opportunities for rapid testing. Continue commissioning in reach clinics.	Procurement Workforce development	ACT PHN

		Many GPs have little or no contact with people living with HIV so the traditional model of referral to a specialist for HIV care is appropriate. There is evidence that many GPs have a poor knowledge of HIV testing and treatment with few having prescribing capabilities. For people with HIV who wish to maintain contact with their regular GP who is not a prescriber, there is often a shared care arrangement with doctors at the Canberra Sexual Health Centre. Engagement with stakeholders indicated that: • Rapid testing opportunities or opportunistic testing may help improve screening rates. • Establishing routines of screening for people with ongoing risk is essential for early detection of infection. • Harm minimisation (NSPs, PrEP, condom use etc.) should be discussed by GPs • Comprehensive STI and BBV screening along with HIV testing is useful in identifying other infections that share similar transmission modes.				
	9.9 Managing and connecting care for families with complex needs	**Families with complex health and social care needs** A family may be experiencing a number of issues relating to poor mental or physical health, financial hardship and finding support for a child with disability. This will involve contact with multiple services and a wide range of providers, usually on a long-term basis, and their care often becomes fragmented. There is often a lack of coordination between all the agencies/services involved. This can result in more hospitalisations and lower patient satisfaction. Not only does this place considerable strain on public resources but there are little or no signs of improvement in the lives of these families. For this reason these patients need a dedicated person/case manager who is responsible for coordinating all their health and social care. This coordinated approach may also include a form of case conferencing for all identified agencies. No case conferencing is available as there is no longer funding for this from NDIS. It is crucial to identify families with complex needs and to assess the characteristics, needs and wants of the family prior to intervening. It is also important to gather information about a family from both the family themselves and other sources where possible (e.g. other service providers or case notes) and to identify and meet immediate needs for practical support and access to other services. The GP plays a key advocacy role for all patients and helps them access the care they need in an increasingly complex system. This advocacy role is particularly important for families with complex health and social care needs. The advocacy role of the GP includes: • helping the patient and/or their family to take an active part in the clinical decision-making process • working with government, non-government and private organisations to maximise equitable services to all members of the community For disadvantaged/vulnerable patients, the GP is ideally placed to facilitate their access to other services and assist them in navigating the health and social system	Primary health care professionals feel supported to identify, manage and refer patients and families with complex needs.	Ensure primary care health professionals can provide client and family-centred care for those with complex health and social care needs through: • Analysis of needs and social determinants of health based on local data • Raising awareness of social supports and services available • Consider models of care and build a business case for services addressing social care within a health context.	Workforce development Procurement	ACT PHN
	9.10 Lack of supports for people with a disability that are not accessing the NDIS	**Disability** GPs may not always be comfortable undertaking the NDIS assessment for a patient and may refer to a specialist, which increases cost. If GPs don't describe the 'impact on	Primary health care professionals feel supported to identify, manage and refer patients and families	Support the sector to understand and address changes in disability services.	Workforce development	ACT PHN

		daily function' sufficiently on a patients NDIS access request form, it may not be approved. There is a perception in the community that a doctor is required to complete the assessment form, however, other clinicians can complete the evidence required on the NDIS forms (and may be more equipped to do this in regards to knowing the patient and the impacts on their daily function). As at 31 December 2016, 752 (10.6%) of NDIS access requests made in the ACT were deemed ineligible. Some of these are due to insufficient GP descriptions. Only 20% of ACT plans were approved within 90 days of an access request being submitted during the third quarter of 2015-16. Early identification and intervention in child development is vital - any delay applying for an NDIS plan, along with the long time it takes once an access request form is submitted to when services begin, can be critical in child's development. GPs need to be aware whether or not their patient has an NDIS plan, and if it is self-managed (a patient can see any provider) or if it is agency managed (a patient can only see registered providers). GPs also need to be aware of who the NDIS registered providers are. The ACT has the highest rate of fully self-managed plans (23%) of all states and territories (national 11%) and the lowest rate of agency managed plans (33%, national 60%). GPs could play a big role in helping and supporting patients and families to navigate the NDIS system.	who are not accessing the NDIS.	• Provide education and support to general practices about NDIS and other services available to clients. • Support activities that increase health literacy and build capacity of clients to navigate complex health needs. • Continue collaborating with the disability sector to ensure integration with health services.	Strategic relationships	
	9.11 Services and resources for those who are not eligible or choose not to access the NDIS	**Disability** If a person is deemed ineligible for the NDIS there is a degree of suffering and stress involved. If it was due to an insufficient description of impact on daily function, it might take quite a while for the individual to gain the confidence to apply again. Clinicians also feel frustrated after putting time and effort into completing the form. Health workers and consumers need the knowledge and support about what services are available to those people who aren't eligible for the NDIS, and an increase in the services available to people who are ineligible for the NDIS. Vulnerable families have a high level of association with the health system and with Care and Protection Services so these services (including GPs) could help in this space. Implications for the health system include some people not being able to access mental health care (due to cost) and excessive waiting times, or there are issues of people presenting to ED because they can't afford other care. Those aged over 65 years cannot access NDIS and rely on My Aged Care, which provides less financial support. Refugees and those on visas are not eligible for the NDIS due to their visa status.	Primary health care professionals have an increased knowledge and confidence in supporting patients to access other social support services.	Support the sector to understand and address changes in disability services. • Provide support to general practices about NDIS and other services available to clients. • Support activities that increase health literacy and build capacity of clients to navigate complex health needs. • Continue collaborating with the disability sector to ensure integration with health services.	Workforce development Strategic relationships	ACT PHN
	9.12 Access to allied health services	**Disability** Allied health services are experiencing high demand and long waiting lists. There are limited NDIS registered services for some domains (e.g. physiotherapy, psychologists, speech pathology, OT). Some allied health providers aren't registering as NDIS providers as they believe they would be financially worse off, or they are registering and then deregistering, allegedly because of the loss of potential income and the undesirable processes that come with the NDIS. Cost and physically getting to the provider can be major access issues for people.	Access to allied health services.	Collaborate with NDIS and professional associations on examining the options for increasing allied health service supply.	Strategic relationship Workforce development	ACT PHN
	9.13 Need for early intervention for children exhibiting	**Disability**	Primary health care professionals are feeling supported to identify,	Provide education and training opportunities to general practice focusing on vulnerable children and	Workforce development	ACT PHN

	challenging behaviours	Speech (language and communication) is the most common issue seen at the ACT Child Development Service. Many of the challenging behaviours exhibited by students at school have a much longer history, often developing in early childhood, before starting school. To minimise the negative impact of these issues on children's behaviour and development, appropriate interventions must start as early as possible (e.g. at the time of their recognition or diagnosis). Supports offered should be tailored to meet the individual needs of children and should be available early, when help is most likely to be beneficial. It is very difficult to target vulnerable children and get them to transition to the NDIS. There are many reasons why families are not transitioning to the NDIS, such as:not aware of additional services that may be available to them (e.g. respite), overwhelming or stressful, misinformation (e.g. lose Centrelink entitlement), fear that the data will be shared with Care and Protection, mistrust of Government, lack of required assistance to support them through the NDIS experience (e.g. trusted knowledge, guidance, transport, paperwork assistance) etc. Even once some participants have been approved for a plan, it is overwhelming to begin and choose their own services, and therefore they may not be using their funding allocation.	manage and refer children with early signs of behavioural concerns.	promote paediatric HealthPathways.		
	9.14 Healthy growth and development	**Early Childhood, Middle Years and Youth** Childhood overweight and obesity impacts around 20.6% of ACT children in the 5–17 year age range. While rates of overweight and obesity in children have remained reasonably stable, significant numbers of children will continue to be at risk of developing serious disease and chronic health conditions in adulthood if action is not taken early in life to prevent childhood overweight and obesity. According to the Australian Early Development Census (AEDC) results, 1,161 (23.2%) kindergarten children in the ACT are developmentally vulnerable in one or more domains. Belconnen saw the greatest rise in developmental vulnerability in each of the domains between 2012 and 2015, with 327 (25.1%) of children developmentally vulnerable in one or more domains.	Developmental concerns are identified early and managed proactively. Parents/carers understand and are engaged in their child's care.	Support primary health care professionals and community care providers to monitor and promote healthy growth in children. Collaborate with ACT Health, ACT Education and Training Directorate and ACT Community Services Directorate for a multi-sector approach to addressing developmental vulnerability.	Workforce development	ACT PHN
	9.15 Identification of children in their middle years in primary health care and the issues associated with this	**Early Childhood, Middle Years and Youth** Primary health care professionals need to be aware of issues that are associated with children in their middle years, including the challenges that puberty and transitioning to high school can bring. Young people in marginalised groups are at higher risk of poor wellbeing, including people with disability; LGBTIQ people; carers; materially disadvantaged people; Aboriginal and Torres Strait Islander people; culturally and linguistically diverse people and people in out of home care. Early identification of mental health issues and healthy growth and development are the most important issues in this period of childhood.	Primary health care professionals are supported to proactively identify and manage risk and concerns in children's middle years. Parents/carers understand and are engaged in their child's care.	Provide education and training opportunities to general practice focusing on vulnerable young people and promote HealthPathways.	Workforce development	ACT PHN
	9.16 Identification and management of children and youth who are in out-of-home care (and their families) in primary health care	**Early Childhood, Middle Years and Youth** As at 30 June 2017, there were 803 children (0-17 years) in the ACT in out-of-home care. Children going into care have usually suffered abuse and neglect and have problematic health issues so need an engaged and effective GP. Children in out of home care are more likely, in the long term, to have poorer health, lower education, increased mental illness, have children earlier and an increased risk of their children being in out of home care. Aboriginal and Torres Strait Islander children are over represented in out of home care in the ACT, accounting for 28% of the children in out of home care, but less than 2% of the total population.	Primary health care providers are supported to understand and identify increased risks for children in out of home care and are pro-actively screening and managing concerns.	Undertake a scoping project to determine the feasibility of out-reach models targeting this population with flexible entry points and offer options for isolated families. Collaborate with ACT Health, ACT Education and Training Directorate and ACT Community Services Directorate for a multi-sector	Workforce Development	ACT PHN

		Vulnerable children can be identified by schools, MACH Nurses, GPs, Community Health Centres and Child and Family Centres. GPs are a critical source of information, referral and support to parents who have limited financial means and who are raising young children on their own. However parents can have difficulties accessing appointments and finding a GP, particularly a GP who bulk bills. Due to the time constraints of a 15 minute appointment, referrals to other support services are often not forthcoming and/or GPs may not be aware of services that exist for families. Research indicates that isolated families access the universal service system (Centrelink, Health, Housing, Education and Child Care). It is after this contact that parents seem to fall through the cracks, often failing to get information or referrals to targeted and intensive support systems designed to help them. Embedding supported linking practices across the service system will greatly increase the ability of targeted services to make contact with families whom those services have found 'hard to reach'. GPs could play a more proactive role and connect parents to formal service support systems.		approach to addressing developmental vulnerability.		
	9.17 Carers have poorer health outcomes	**Carers** Approximately one in eight (44,800) ACT residents provide unpaid care for a family member or friend. Four in five carers report below average wellbeing, with carers in Australia reporting the lowest personal wellbeing of any large population group. Access to primary health care is difficult because their own health needs are not prioritised (by themselves individually, families etc.). Carers often ignore their own health and are 40% more likely to suffer from a chronic health condition. Many carers are chronically tired and desperately need to refresh with just one night of unbroken sleep, a day off or an extended period with no caring responsibilities. As a population group, carers generally have a lower income and a lower standard of living than other population groups in Australia. This means that carers are at-risk of poor health and wellbeing due to the social and socioeconomic determinants of health. Providing carers with the opportunity for their own health assessment (e.g. blood pressure, stress levels, physical injuries related to caring and management of chronic health conditions) could positively assist carers' health and wellbeing. Carers are likely to feel better supported if they can access health professionals who ask about and help them manage their own health needs.	Improved engagement in health services among carers. Improved health outcomes for carers.	Research and scope models of care that support carers to access health care within the context of their role as a carer and support their physical and mental wellbeing. Collaborate with Carer organisations to explore opportunities for outreach models that meet the needs of carers. Provide support to primary health care professionals to assist in recognising and addressing the health needs of carers.	Procurement Workforce development	ACT PHN in partnership with Carers ACT
	9.18 Need for increased support and improved literacy for carers to effectively engage with the NDIS	**Carers** Some carers struggle to understand and therefore embrace the NDIS (e.g. unclear language, inadequate communication with carers about what to expect etc.) Many carers don't feel prepared when the person they care for first applies for the NDIS and even after receiving a plan, many have little or no understanding of the NDIS. While the NDIS relies heavily on carers, through the NDIS there is no formal assessment of carers' needs, no funding package for carers and no guarantee of involvement in the assessment of the care recipient's needs. There is a potential loss of funded supports for carers, particularly when the person they are caring for isn't eligible for the NDIS. There are health consequences for carers due to the stress associated with the NDIS (services not being provided; people not eligible). A survey conducted by Carers ACT found the NDIS had not improved outcomes for many carers in the ACT, for example, 63% found their time spent managing the support needs of the person they cared for had increased.	Carers feel supported to navigate the NDIS.	Collaborate with the disability sector and carer organisations to deliver health literacy activities that focus on the NDIS and navigating complex health and social care systems.	Community awareness	ACT PHN in partnership with Carers ACT

References

360Edge and Alcohol Tobacco and Other Drug Association (ATODA). (2017). *The specialist alcohol, tobacco and other drug sector: a description and examination of treatment and support approaches.* ACT: Alcohol Tobacco and Other Drug Association.

Australian Institute of Health and Welfare. (2017). *National drug strategy household survey detailed report 2016: detailed findings.* Canberra: Australian Institute of Health and Welfare.

Dietze, P. (2016). Current drug trends and responses. *Australian Parliamentary Drug Summit 2016.* Canberra: Parliamentary Group on Drug Policy and Law Reform.

Penington Institute . (2018). *Australia's Annual Overdose Report.* Melbourne: Pengington Institute.

Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K., & Gomez, M. (2014). *New Horizons: The review of alcohol and other drug treatment services in Australia.* Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

Section 3 - Checklist

Requirement	✓
Governance structures have been put in place to oversee and lead the needs assessment process.	✓
Opportunities for collaboration and partnership in the development of the needs assessment have been identified.	✓
The availability of key information has been verified.	✓
Stakeholders have been defined and identified (including other PHNs, service providers and stakeholders that may fall outside the PHN region); Community Advisory Committees and Clinical Councils have been involved; and Consultation processes are effective.	✓
The PHN has the human and physical resources and skills required to undertake the needs assessment. Where there are deficits, steps have been taken to address these.	✓
Formal processes and timeframes (such as a Project Plan) are in place for undertaking the needs assessment.	✓
All parties are clear about the purpose of the needs assessment, its use in informing the development of the PHN Activity Work Plan and for the department to use for program planning and policy development.	✓
The PHN is able to provide further evidence to the Department if requested to demonstrate how it has addressed each of the steps in the needs assessment.	✓
Geographical regions within the PHN used in the needs assessment are clearly defined and consistent with established and commonly accepted boundaries.	✓
Quality assurance of data to be used and statistical methods has been undertaken.	✓
Identification of service types is consistent with broader use – for example, definition of allied health professions.	✓
Techniques for service mapping, triangulation and prioritisation are fit for purpose.	✓
The results of the needs assessment have been communicated to participants and key stakeholders throughout the process, and there is a process for seeking confirmation or registering and acknowledging dissenting views.	✓
There are mechanisms for evaluation (for example, methodology, governance, replicability, experience of participants, and approach to prioritisation).	✓